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I am here today as a registered dietitian and a member of the Wisconsin Dietetic Association to voice my **support for Senate Bill 30**, relating to permitting a mother to breastfeed in any public or private location where she is otherwise authorized to be.

It is the position of the American Dietetic Association, a professional organization of 70,000 nutrition experts, that exclusive breastfeeding provides optimal nutrition and health protection for the first six months of life, and breastfeeding with complementary foods for at least twelve months is the ideal feeding pattern for infants. Breastfeeding is also a public health strategy for improving infant and child health survival, improving maternal morbidity, controlling health care costs, and conserving natural resources.

For all these reasons as well as the fact that nursing one's child is a natural, positive, bonding behavior; breastfeeding should be encouraged in our society. For decades, communities have been planned which encourage optimal travel by car. Finally, more emphasis is turning toward planning communities that encourage walking. Likewise, it's time for communities to plan in a way that encourages mothers to choose the healthiest alternative for feeding their infants—which is breastfeeding.

My name is Karissa Andrews, and I'm here to share my story of breastfeeding harassment.

When my second child was 3 weeks old, I was shopping at a Madison Mall with my family. My baby was hungry, so I sat down on a bench in a common area of the mall and nursed him.

I had only been there a minute or two before I noticed a woman working at a nearby kiosk staring at me, and talking to a security guard.

Then she came over to where I was sitting with my children and began telling me that I wasn't allowed to breastfeed there, and I would have to move to a location near the restroom. She told me mall policy prohibited breastfeeding ~~there~~.

~~so angry and embarrassed, it was~~
~~clear to me that it was her own discomfort with my~~
~~nursing that she represented, not the~~
~~mall policy.~~ I later confirmed this with the mall

~~manager~~. I later found out she was wrong about the policy, but that did not prevent her from continuing to harass me, getting louder and attracting attention from onlookers, scaring my 4yo. She finally warned me she had alerted security, and I looked up to see that the one security guard had come back with two more guards. They seemed uncertain about what to do, but they circled around me, pointing and talking to each other.

I decided to leave that uncomfortable situation before it got worse. I felt terrible, and I had to explain to my young daughter why mommy was being treated that way for trying to take care of her baby brother.

I honestly felt I was treated like a common criminal for feeding my baby.

My story is one of many. After speaking with other moms who have similar stories, I know this is a real problem, and some women are even choosing to not to breastfeed to avoid such harassment. If this does not change, there will be serious health consequences for WIC children.

Karissa Andrews

SB30

Room 411 S

Tuesday 5.15.97

SB 30 MLF

Distinguished members of this Senate Committee:

Thank you for taking the time to listen to our support for Breastfeeding Protection Act (SB 30), here in the great state of Wisconsin.

<Prayer gesture: statue of Our Lady of Le Leche; The Blessed Virgin Mary breastfeeding her son, Jesus, the son of God.>

I am here as a Catholic, pro-life, homeschooling, breastfeeding mom. I am here representing many Christian pro-life, homeschooling, breastfeeding moms who came before me, and those who will come after me; including my own daughters and my future grandchildren.

The Breastfeeding Protection Act is necessary to protect the rights of breastfeeding mothers who happen to be in public when their children get hungry. I am grateful for the mothers who came before me; the breastfeeding moms who were expected to nurse their children on toilet seats, in dressing rooms, or go back to their vehicles when they ventured out with their nursing children. I am grateful for the nursing mothers in this room and for all those who have ventured out recently and refused to be intimidated into nursing in hiding. The Breastfeeding Protection Act, if passed, will make all mothers who feed their children in public equal: those who choose to bottle feed and those who choose to breastfeed.

I chose to breastfeed my four children because The Academy of Pediatrics and other esteemed health authorities recommended it, for at least the first year of my baby's life. Originally, it was the health benefits and the recommendations of "health authorities" that led me to choose breastfeeding over formula feeding, but even more importantly, I chose to breastfeed my children because my Christian faith encouraged me to embrace my vocation as a mother, a vocation that is increasingly denigrated in modern American culture, as the need for this legislation indicates. I am forever indebted to La Leche League, for giving me the information, support and encouragement that allowed me to successfully breastfeed my children; breastfeeding gave me the tools I needed in order to become the mother I've always wanted to be!

I began my nursing career in The Land of 10,000 lakes, a state that protects a woman's right to breastfeed in public. I was shocked by the harassment I received when I moved back to my home state of Wisconsin in the fall of 2001! I have had several harassment incidents; let me tell you about one of them. I was attending a children's birthday party with my oldest child and my newborn. The party was at a public pool—a family friendly place. I was nursing my baby and talking with the other parents at the party when a teenage life-guard approached me and told me that I needed to stop "doing that" because I was bothering

people. I was wearing a maternity-nursing shirt at the time. She was wearing a low-cut swim suit. Thank goodness I was all ready confident in my decision to breastfeed my baby, even in public, or she might have scared me into being homebound for my entire post-partum!

I have been around breastfeeding mothers for an entire decade. I have been actively involved in La Leche League groups, The Couple to Couple League-an NFP organization that promotes ecological breastfeeding, Sacred Heart Homeschoolers, a Catholic homeschooling group here in Madison where the average family size is 5 children....I have seen more women baring their breasts on the grocery store news stand than I have ever seen during the past ten years I've spent hanging out with breastfeeding mothers.

God's plan for motherhood is simple to figure out: a baby grows in a woman's uterus and right after she gives birth, milk flows into her breasts so that she can feed her child. God designed the breast as a feeding organ first and foremost. He did not objectify it as a pleasure-toy. We did. The pornification of our culture has lost touch with God's plan. The pornification of the female body has created the disordered view that a mother feeding her child at the breast is lewd and instills lust for those near by. Every nursing mother I have ever known dresses modestly and nurses modestly; someone would have to stare long and hard in order to figure out if a nursing mother was indeed nursing, or just holding a sleeping child. If, after staring for so long the onlooker is feeling lustful or disgusted, then s/he is certainly capable of looking away. I have to look away when I see parents in public who are making choices I would not make. My husband has to look away when a Victoria Secret ad assaults him visually, in order to be faithful with his eyes to me, in marriage. Looking away is an option for everyone.

I don't know any mother who sets out with her homeschool crew in tow, on a fieldtrip, or to attend a homeschool event with the sole intention of breastfeeding her nursling in public. Breastfeeding mothers are simply responding to the needs of their children. Why should they be harassed for meeting the needs of their children?

I have a friend who travels regularly to Guatemala. I asked her once, what the breastfeeding mothers do there. She told me that the mothers carry a mat on their back and when their children need to breastfeed, they put the mat down, wherever they are, right in the middle of the street, and nurse their children and often fall asleep on the spot. It's hard for me to believe that breastfeeding mothers in Guatemala have more rights to breastfeed in public than I do here in America's Dairyland. I hope that will soon change.

I would like to close by listing all of the Bible passages I've found so far that mention breastfeeding: 1Samuel 1: 22-24, Numbers 11:12, 2 Maccabees 7:27, Psalm 22:9, Joel 2:16, Thessalonians 2:7 and my personal favorite: Isaiah 66: 10-13, which reads: *"Rejoice, with Jerusalem, and be glad for her; rejoice with her in joy, all you who mourn over her; that you may suck and be satisfied with her consoling breasts; that you may drink deeply with delight from the abundance of her glory, For thus says the Lord: Behold, I will extend prosperity to her like a river, and the wealth of the nations like an overflowing stream; and you shall suck, you shall be carried upon her hip, and dandled upon her knees. As one whom his mother comforts, so I will comfort you; you shall be comforted in Jerusalem."*

If the word of God is full of breastfeeding passages, and if God allowed His only Son to be nursed at The Blessed Virgin Mary's breast....how could there be anything crude, rude, or indecent about breastfeeding anywhere?

Thank you for your time and attention.

Mary Laurel Fabian

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M.Ed. School Counseling, Marquette University 1991
La Leche League Member/Leader 1997-present
Couple to Couple League NFP Teacher/Member 1998-present
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Position of the American Dietetic Association: Promoting and Supporting Breastfeeding

ABSTRACT

It is the position of the American Dietetic Association (ADA) that exclusive breastfeeding provides optimal nutrition and health protection for the first 6 months of life, and breastfeeding with complementary foods for at least 12 months is the ideal feeding pattern for infants. Breastfeeding is also a public health strategy for improving infant and child health survival, improving maternal morbidity, controlling health care costs, and conserving natural resources. ADA emphasizes the essential role of dietetics professionals in promoting and supporting breastfeeding by providing up-to-date, practical information to pregnant and postpartum women, involving family and friends in breastfeeding education and counseling, removing institutional barriers to breastfeeding, collaborating with community organizations and others who promote and support breastfeeding, and advocating for policies that position breastfeeding as the norm for infant feeding. ADA also emphasizes its own role by providing up-to-date information to the public, encouraging empirical research, providing continuing education opportunities, providing cultural sensitivity and cultural competence training to dietetics professionals, and encouraging universities to review and update undergraduate and graduate training programs.

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POSITION STATEMENT

It is the position of the American Dietetic Association (ADA) that exclusive breastfeeding provides optimal nutrition and health protection for the first 6 months of life, and breastfeeding

with complementary foods for at least 12 months is the ideal feeding pattern for infants. Breastfeeding is also a public health strategy for improving infant and child health survival, improving maternal morbidity, controlling health care costs, and conserving natural resources.

reastfeeding, or lactation, is the ideal method of feeding and nurturing infants. The Bellagio Child Survival Study Group identified breastfeeding in the first year as one of the most important strategies for improving child survival (1-3). Health professionals in the United States recommend that infants be exclusively breastfed for the first 6 months of life, and then be breastfed with complementary foods for at least the first year (4-8). Internationally, the World Health Organization recommends that breastfeeding be continued up to 2 years of age or beyond, with appropriate supplementation of solid foods (9,10). Breastfeeding involves primary, and to a lesser extent, secondary prevention of acute and chronic diseases. Achieving the Healthy People 2010 objectives (4) for breastfeeding could lead to a significant decrease in pediatric health care costs in the United States (11). The benefits of breastfeeding are well recognized and include decreased infant and child morbidity and mortality, protection against common childhood infections, and decreased risk of certain acute and chronic diseases. There are also extensive health benefits for mothers who breastfeed (4,10).

BREASTFEEDING TRENDS IN THE UNITED STATES

Breastfeeding rates in the United States are lower than in most nations. Globally, about 79% of infants are breastfed for 12 months, compared with 17% to 20% in the United States (10,12,13). In colonial America, almost all infants were breastfed. By

the 1880s, mothers began to supplement breastfeeding with raw cow's milk (some starting soon after giving birth) and to wean their infants before they were 3 months old. Infants fed raw cow's milk died at much higher rates than breastfed infants until the 1920s, when pasteurization made cow's milk safer and readily available for infant feeding. Over the next 50 years, breastfeeding rates declined sharply because of the widespread belief that pasteurized cow's milk eliminated the differences between human and cow's milk feeding (14). The decline continued when other milk substitutes (evaporated cow's milk and infant formula) became widely available. These were promoted as being more convenient for the mothers and being more nutritious than human milk. Breastfeeding rates reached an all-time low in the United States in 1971, with only 24% of mothers initiating breastfeeding (15).

As a result, the US Department of Health and Human Services (HHS) set goals for breastfeeding initiation and duration rates in the late 1970s. The United States has since seen a steady increase in breastfeeding rates (4). Breastfeeding initiation rates increased from a low of about 24% in the early 1970s to a high of 61.9% in 1982 (15,16). After a decline in breastfeeding rates through 1990, breastfeeding initiation rates have increased yearly, exceeding 70% in 2002 (12,13) (Figure 1). Breastfeeding rates are expected to continue increasing as a result of several national efforts, including the HHS *Blueprint for Action on Breastfeeding* (5), the US Department of Agriculture (USDA)/Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) *Loving Support Makes Breastfeeding Work* campaign (17), the HHS *Breastfeeding Awareness Campaign* (18), and the US Breastfeeding Committee's strategic

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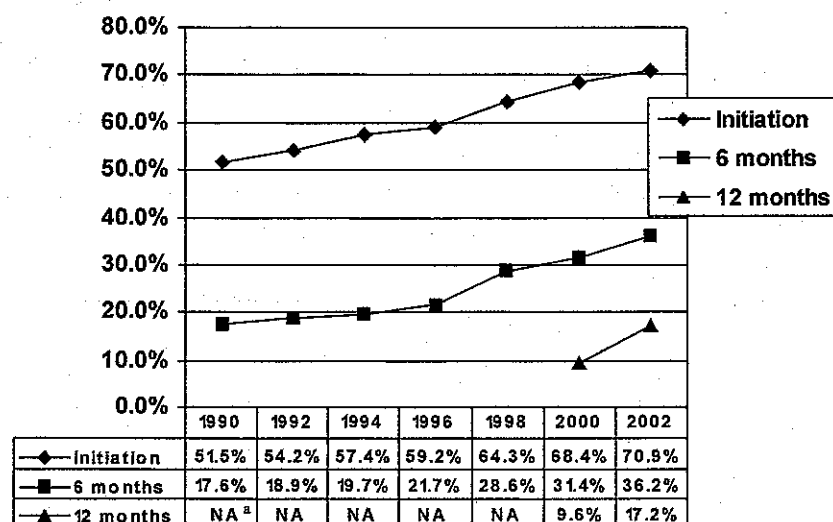


Figure 1. US breastfeeding rates (1990 to 2002). 1990 to 2000 data from reference (12). 2002 data from reference (13). ^aNA=not available.

plan for breastfeeding (19). The US Breastfeeding Committee's strategic plan is endorsed by HHS and more than 20 other professional and public health organizations.

According to National Immunization Survey data, 14 states have achieved the national Healthy People 2010 objective for 75% of mothers initiating breastfeeding (Figure 2), and the national goal seems to be within reach (13). Breastfeeding initiation rates continue to be highest among women who are white, college educated, older than 30 years, employed part-time, not enrolled in WIC, and living in the Mountain or Pacific regions (12,13). Although all demographic groups reported increases in breastfeeding initiation since 1990, the largest increases occurred among mothers who have historically been less likely to breastfeed—women who are black, Hispanic, less educated, employed full-time, less than 24 years old, living in the South Atlantic region, participating in WIC, and with low-birth-weight infants (12).

Considerable work remains to achieve the two Healthy People 2010 goals for breastfeeding duration—50% of infants breastfeeding at 6 months of age and 25% breastfeeding at 12 months of age (4). Six states have achieved the objective for breastfeeding duration at 6 months of age (see Figure 2). However, nationally only 33.2% to 36% of all infants are breastfeeding at 6 months of age

(12,13). The largest increases in breastfeeding duration rates have occurred among New England residents, Hispanic mothers, and non-WIC participants (12). Eight states have achieved the objective for breastfeeding duration at 12 months of age (see Figure 2). Nationally, only 17% to 20% of all infants are breastfeeding at their first birthday (12,13). Worldwide, 79% of infants are still breastfeeding at 12 months of age (10).

US breastfeeding initiation rates are much higher than breastfeeding exclusivity rates. Despite the limited data about breastfeeding exclusivity and the variety of definitions of exclusivity used across studies, the available data provide important insight. Exclusive breastfeeding in hospitals has remained steady over the last 4 years, but significant differences exist by demographic segments. For example, mothers with a college education are more likely to have exclusively breastfed their infants than mothers without a college education. Non-WIC mothers exclusively breastfed their infants at higher rates than WIC mothers, and white mothers exclusively breastfed at a rate nearly double that of black mothers. At 6 months of age, similar gaps existed for these same demographic segments (12,13).

The primary source of breastfeeding data in the United States since 1955 has been proprietary data collected by Ross Products Division of

Abbott Laboratories. The Ross Mothers Survey (12) collects data through an ongoing mail survey periodically sent to a nationally representative sample of new mothers. The data have been relied on to monitor breastfeeding rates by state, by geographic region, and nationally. Another data source for monitoring breastfeeding trends was instituted in 2003 by the Centers for Disease Control and Prevention and the National Center for Health Statistics (13). Breastfeeding questions were incorporated into the National Immunization Survey, which uses random-digit dialing to survey households with children ages 19 to 35 months. Breastfeeding initiation, duration, and exclusivity of breastfeeding rates are reported for the overall population, states, and selected geographic areas within states. Trend data from the latter survey will be critical for monitoring breastfeeding rates in the future.

HEALTH BENEFITS TO INFANTS

According to the American Academy of Pediatrics, the breastfed infant is the reference against which all alternative feeding methods must be measured with regard to growth, health, development, and other outcomes (6). Human milk has many beneficial effects on the health of infants (including premature and low-birth-weight infants) and young children. These benefits are magnified with exclusive breastfeeding and breastfeeding beyond 6 months of age (3,10).

Human milk is uniquely superior to all other milk substitutes and is specifically tailored to meet the nutritional needs of the human infant. It has the appropriate balance of nutrients provided in easily digestible and bioavailable forms (4,10,20). The milk changes its composition, from colostrum for the newborn to mature milk for the older infant, to meet the nutrient needs of the growing infant. It provides generous amounts of carbohydrates, essential fatty acids, saturated fatty acids, medium-chain triglycerides, long-chain polyunsaturated fatty acids, and cholesterol. The relatively low protein content presents a relatively modest nitrogen load to the immature kidney. The protein is largely α -lactalbumin, a whey protein that forms a soft, easily di-

75% Breastfeeding initiation	50% Breastfeeding at 6 months	25% Breastfeeding at 12 months
Alaska Arizona California Colorado Hawaii Idaho Kansas Minnesota Montana Nevada Oregon Utah Vermont Washington	Hawaii Idaho Oregon Utah Vermont Washington	Alaska California Hawaii Idaho Oregon Utah Vermont Washington

Figure 2. States achieving national Healthy People 2010 breastfeeding objectives. Source: Centers for Disease Control and Prevention. 2003 National Immunization Survey.

Benefits for infant	Benefits for mother
<ul style="list-style-type: none"> • Provides optimal nutrition for infant • Guarantees safe, fresh milk • Enhances immune system • Protects against infectious and non-infectious diseases • Protects against allergies and intolerances • Decreases risk of diarrhea and respiratory infections • Promotes correct development of jaws, teeth, and speech patterns • Decreases risk of childhood obesity • Increases cognitive function • Reduces risk for heart disease • Increases bonding with mother 	<ul style="list-style-type: none"> • Promotes faster shrinking of the uterus • Reduces postpartum bleeding • Decreases risk of breast and ovarian cancer • Delays resumption of the menstrual cycle • Improves bone density • Decreases risk for hip fracture • Improves glucose profile in gestational diabetics • Strengthens bond with the infant • Enhances self-esteem in the maternal role • Eliminates the need for preparing and mixing formula • Saves money not spent on formula

Figure 3. Benefits of breastfeeding.

gestible curd. Human milk has a relatively low sodium content, allowing the fluid requirements of the exclusively breastfed infant to be met while keeping the renal solute load low. Minerals in breast milk are largely protein bound and balanced to enhance bioavailability. The 2:1 calcium-to-phosphorus ratio is ideal for the absorption of calcium, phosphorus, and magnesium. The limited amount of iron and zinc is highly absorbable (21). Given the nutrient content of human milk and decreased exposure to sunlight, a vitamin D supplement is recommended for all breastfed infants until they consume at least 500 mL per day of vitamin D-fortified infant formula (or milk for infants after their first birthday) (22). Breastfed infants who are 6 months and older may need a fluoride supplement if the total amount of fluoride from the local

water supply or other sources available to the infant is inadequate (23).

Breastfeeding, especially exclusive breastfeeding, during the first 6 months of life is an important factor in reducing infant and childhood morbidity and mortality (9). Breastfeeding decreases the risk for a large number of acute and chronic diseases (Figure 3). Breastfeeding decreases the incidence and severity of diarrhea and gastrointestinal illnesses (24,25), lower respiratory infection (26), otitis media (24,25,27), bacterial meningitis (28,29), necrotizing enterocolitis (30), malocclusions or misalignment of teeth (31), allergic diseases (30), childhood asthma (32), childhood leukemia (33), childhood obesity (34), and Sudden Infant Death Syndrome (SIDS) (35). Evidence continues to accumulate confirming the benefits

of breastfeeding in reducing the risk for cardiovascular diseases and type 1 diabetes (36). Breastfeeding also has been linked with enhancement of cognitive development, with some studies showing evidence that these cognitive developmental benefits increased with the duration of breastfeeding (37) and extended through the school-age years (38,39).

Studies relating to the benefits of breastfeeding have been criticized for methodological and analytical flaws including lack of control for confounding factors, poorly designed tools, varying definition of breastfeeding, and researcher bias (11,40). However, professional health organizations stand behind their recommendations for promoting breastfeeding as the optimal food for human infants.

HEALTH BENEFITS TO WOMEN, FAMILY, AND SOCIETY

Maternal Benefits

Women choose to breastfeed for many reasons. Although women may be aware of the health benefits to infants, they may not be fully aware of the wide range of health benefits for themselves (see Figure 3). The degree to which some of these health benefits may be realized depends on breastfeeding duration, frequency, exclusivity, and other personal factors (41). Breastfeeding increases oxytocin levels, resulting in less postpartum bleeding and greater uterine involution (shrinking) (42). Lactation amenorrhea (delayed menstrual cycle) causes less menstrual blood loss, which conserves iron stores (42). Other benefits of breastfeeding include a decreased risk for postmenopausal hip fractures (43), bone remineralization to levels exceeding those present before pregnancy (44), an improved glucose profile for those with gestational diabetes (45), a decreased risk of type 2 diabetes (41), a decreased risk for ovarian cancer (46), a decreased risk for premenopausal breast cancer (47), and increased weight loss and fat loss (48-50).

The studies on breastfeeding and weight loss have produced mixed findings. In the short term, breastfeeding women experience greater weight and fat loss than nonbreastfeeding women (48,49). Women who breastfeed for more than 6 months and those who do so exclusively are more likely to achieve maximum weight loss. However, the weight difference may not be sustained past 18 months (50). It should be noted that weight loss and body composition changes are highly variable among postpartum women (50,51). In addition, prepregnancy weight and total pregnancy weight greatly impact postpartum weight loss (50).

Economic Benefits

Breastfeeding provides significant economic benefits to the family and society. Breastfeeding allows the family to save the money that otherwise would be spent on infant formula, other milk substitutes, and feeding equipment. It also improves household food security and saves the family's disposable income for food for older children and adults. Families that do not breastfeed

spend close to \$700 for standard formulas in the first year. Other direct family savings include the defrayed or reduced health care-related expenses. (11,52,53). Indirect costs to the family include time and income lost from work to take care of a sick child (11).

There also would be economic benefits to the nation if more women would breastfeed. The USDA estimates that at least \$3.6 billion could be saved in health care costs if breastfeeding rates were increased from current levels to those recommended by the US Surgeon General. The savings could be much higher because this figure only represents cost savings from the treatment of three childhood illnesses (otitis media, gastroenteritis, and necrotizing enterocolitis) (11). It is also estimated that \$30 million would be saved if all of the women in WIC breastfed for 1 month. An additional \$48 million could be saved if 75% of the mothers in WIC breastfed for 3 months (11,52,53). In addition to the savings in direct medical costs, data are emerging that document the economic benefits of breastfeeding support to employers, including lower maternal absenteeism attributable to infant illness, increased employee loyalty, improved productivity, and enhanced public image (11,54). Breastfeeding is a cost-effective and socially beneficial health practice that should be encouraged and supported.

Environmental Benefits

Breastfeeding contributes to the health of the environment in numerous ways (55,56). Human milk is a natural resource that is renewable with each pregnancy. It is produced and delivered to the consumer without using and wasting other resources, and it creates no pollution. In contrast to infant formula, human milk does not require manufacturing, packaging, shipping, disposing of containers, or extensive advertising. It also conserves natural resources such as fossil fuels. By delaying the return of menses (57), breastfeeding suppresses fertility and increases birth spacing, improving maternal and child health while limiting population growth.

BARRIERS TO BREASTFEEDING

Despite the many benefits of breastfeeding, many women still choose not to do so. The reasons include inadequate knowledge of the benefits of breastfeeding (58), embarrassment and social reticence (59,60), lack of interest or negative perception of breastfeeding (59,61,62), lack of support from partner and family members (59,60,62), partner's negative perception of breastfeeding (63), mother not breastfed as a child (63), the need to work or go to school (59,62), other family responsibilities (59), perceived decrease in father-child bond (59), and aggressive marketing by infant formula companies (64).

Although the majority of American mothers initiate breastfeeding, less than one third continue to breastfeed at 6 months postpartum. Reasons for early termination of breastfeeding include inconvenience (62), perceived restriction of freedom and independence (59), the need to work or go to school (59), embarrassment and societal disapproval (59,60), discomfort about breastfeeding in public (59,60), short or unpaid maternity leave (59,60), unsupportive work environment (59), lack of public and workplace facilities to breastfeed comfortably (59), early supplementation with formula or other milk substitutes (65), pacifier use (65), unsupportive health care environment (65), inconsistent implementation of breastfeeding promotion policies (66), and limited availability of lactation consultant services, especially after hospital discharge (65). Providing samples of infant formula in physician offices, in clinics, and on hospital discharge promotes maternal-infant separation, undermines maternal confidence, and contributes to early mixed feedings that interfere and sometimes interrupt establishing an adequate milk supply (63,64).

SPECIAL CONSIDERATIONS

The advantages of breastfeeding and the use of human milk are particularly salient for premature and low-birth-weight infants. If these infants are unable to nurse, the mother's milk can be administered through various feeding routes, although fortification may be needed to achieve adequate growth (21,67). Human

milk has also been successfully used with infants with cleft palate, cystic fibrosis (with pancreatic enzyme replacement), Down syndrome, and in-born errors of metabolism, especially phenylketonuria (with careful supplementation of low-phenylalanine formula) (21). In each of these situations, mothers need support from health care providers to achieve and maintain an adequate milk supply. Health care providers should provide anticipatory support and be alert to early signs or symptoms of feeding difficulties so that effective early intervention can be initiated.

Despite the many benefits of breastfeeding, there are some situations in which the infant should not be breastfed. These include galactosemia (6) and the infant whose mother uses illegal drugs (68), has active tuberculosis (6,69), is infected with the human immunodeficiency virus (HIV), has acquired immunodeficiency syndrome, or has other diseases in which the immune system is compromised (6,70). In countries with a high prevalence of HIV/acquired immunodeficiency syndrome, the infant mortality risks associated with not breastfeeding may be greater than the risk of acquiring HIV (71).

Medical advances have improved the health outcomes of many pregnant women with chronic diseases such as type 1 diabetes mellitus, systemic lupus erythematosus, and hypothyroidism. However, few data exist to provide guidance to these women if they choose to breastfeed (21). Guidelines are available regarding the advisability of breastfeeding in women with infectious diseases and other maternal conditions (21). The key to successful breastfeeding for these women is the appropriate choice of medications, treatments, and lactation support from the early prenatal to the postpartum period.

Most prescribed and over-the-counter medications are safe for the breastfed infant, and resources are available to assist in evaluating the safety of drug use in lactation (21,68,72). However, there are a few medications that mothers may need to take that may make it necessary to interrupt breastfeeding. They include radioactive isotopes, antimetabolites, cancer chemotherapy agents, lithium, ergotamine, and a small number of other medications (68). Breastfeeding

mothers should be encouraged to discuss any use of prescription drugs, over-the-counter drugs, and herbal medications with their primary care providers. Although herbal products are widely used in the United States, data are lacking about the safety of their use during lactation.

With the exception of maternal chemical poisoning, human milk remains a safe feeding method for infants and young children. Contamination of breast milk with environmental pollutants is a concern when mothers have had specific exposure to heavy metals or insecticides (73). In situations in which maternal exposure and probability of transfer in breast milk lipids are determined to be significant, analysis of milk is recommended, with decisions regarding safety being made from estimated average intake. Environmental contaminants get into human milk when mothers have had geographic, occupational, or accidental exposure. Dioxins produced during industrial processes and organochlorine pesticides and polychlorinated biphenyls are of greatest concern because of their long half-lives and their contribution to the mother's and infant's overall body burden of contaminants (74). Research shows that the greatest risk period for adverse effects from exposure is prenatally (75).

Breastfeeding mothers should be encouraged to reduce their own exposure to known chemical contaminants. For example, women who may become pregnant, who are pregnant, or who are breastfeeding should reduce their exposure to methylmercury (76). Large bottom-dwelling fish are the most common food source of methylmercury, so the Food and Drug Administration and the Environmental Protection Agency recommend the following guidelines for eating fish:

- Avoid shark, swordfish, mackerel, and tilefish.
- Eat up to 12 oz of other kinds of fish every week, with a maximum of 6 oz of albacore (white) tuna per week.
- Check local advisories about eating locally caught fish. If no advice is posted, limit intake of locally caught fish to 6 oz per week and consume no other fish in that same week (77).

ROLE OF DIETETICS PROFESSIONALS IN PROMOTING AND SUPPORTING BREASTFEEDING

As experts in food and nutrition throughout the life cycle, it is the responsibility of dietetics professionals to promote and support breastfeeding for its short-term and long-term health benefits. The ADA emphasizes the essential role of dietetics professionals in promoting breastfeeding as the norm for infant feeding; supporting local, state, and national efforts to increase breastfeeding initiation, duration, and exclusivity rates; reducing individual, social, and institutional barriers to breastfeeding; and increasing access to lactation care and services. The ADA recommends the following strategies to promote and support breastfeeding:

Counsel and Educate Prenatal and Postpartum Women

- Recognize and respect that breastfeeding is a personal decision. Effective educational strategies that strike a balance of support and education result in informed decisions about infant feeding, not guilt.
- Provide women with practical information about breastfeeding that addresses their specific questions and concerns. This patient-centered approach may help dietetics professionals identify breastfeeding problems early and prevent unnecessary or premature weaning.
- Target women who are less likely to breastfeed (eg, racially and ethnically diverse groups, low education levels, adolescents) and counsel in a culturally relevant and sensitive manner. Adolescents need to hear that breastfeeding strengthens the bond with their infants.
- Identify mothers who are at risk for early cessation. The first 6 weeks are especially crucial. Predictors of early cessation include education level, working intentions, workplace support, social support, and previous breastfeeding experience (77).
- Encourage overweight and obese women to achieve a healthful weight before pregnancy. Overweight and obese women who are lactating may have a lower prolactin response, which may result in decreased milk production and

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within 1 hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless *medically* indicated.
7. Practice "rooming in"—allow mothers and infants to remain together 24 hours a day.
8. Encourage unrestricted breastfeeding.
9. Give no artificial teats or pacifiers to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Figure 4. Ten steps to successful breastfeeding for hospitals. World Health Organization and United Nations Children's Fund, 1989. Source: reference (81) Baby Friendly USA, www.babyfriendlyusa.org.

early cessation of breastfeeding (78).

- Provide appropriate and timely information on weaning. The decision to wean should be based on the desires and needs of each breastfeeding dyad. Ideally, weaning should be gradual and solid foods should be offered based on the age and developmental stage of the child.
- Encourage women who are returning to work or school to explore their options for continuing to breastfeed. Discuss on-site arrangements to express and store milk for later use. For women who cannot pump or hand express on site, discuss how to supplement breastfeeding with formula while apart and breastfeed when with the infant.
- Evaluate client education materials and service delivery sites for product bias. Changes should be made to the counseling environment to clearly communicate that breastfeeding is the norm for infant feeding.

Involve Family and Friends

- Identify support networks as early in pregnancy as possible, and develop programs and materials aimed at partners, parents, and grandparents.
- Include partners and grandmothers in breastfeeding education and counseling sessions. Support from a woman's partner and her mother significantly increase her chances of breastfeeding and continuing to breastfeed. Partners need to learn how to be part of a successful breastfeeding family.

Enhance Professional Development

- Participate in continuing education programs to keep up-to-date with the art and science of lactation. Intensive courses in lactation training and education are available through various organizations.
- Consider completing the requirements to obtain the voluntary credential (International Board Certified Lactation Consultant), through the International Board of Lactation Consultant Examiners (79,80).
- Participate in continuing education programs on cultural competence. The low prevalence of breastfeeding among racial/ethnic minority groups demands ongoing training in cultural competence. Dietetics professionals must ask questions and invite dialogue to identify and understand the specific barriers for a group, then design or refine services and messages to address those barriers. Focusing on hands-on interventions, skill building, and problem solving can begin the process of social change.
- Conduct critical internal reviews of undergraduate and graduate dietetics training programs to ensure that nutrition and lactation, lactation physiology, breastfeeding management, and cultural competence are incorporated into curricula. This will ensure that dietetics professionals entering the field understand the health implications of breastfeeding. There also is a need to recruit more racially and ethnically diverse students into dietetics training programs.

Initiate Institutional Change

- Initiate and create institutional and organizational policies to reduce or eliminate institutional bias (eg, hospitals, clinics) for infant formula and incorporate appropriate lactation promotion and support policies in their place. Dietetics professionals must present the breastfed infant as the standard against which infants fed human milk substitutes are compared.
- Encourage hospitals and birthing centers to adopt The Ten Steps to Successful Breastfeeding for Hospitals as outlined by the United Nations Children's Fund/World Health Organization and promoted by Baby-Friendly USA (81). (See Figure 4.)

Collaborate with Others Who Promote Breastfeeding

- Participate in professional and volunteer activities. Collaborative opportunities exist for ADA members to work with the International Lactation Consultant Association, La Leche League International, Nursing Mothers' Counsel, Healthy Mothers Healthy Babies coalitions, state and local WIC programs, the National WIC Association, the African American Breastfeeding Alliance, and breastfeeding task forces at all levels to promote and support breastfeeding.

Initiate and Support Breastfeeding Campaigns

- Work with pro-breastfeeding organizations to promote breastfeeding as the social norm.
- Support extending the reach of

breastfeeding promotion campaigns to men, grandmothers, and adolescent mothers.

- Initiate campaigns that promote breastfeeding exclusivity and breastfeeding beyond 6 months. Breastfeeding is more than meeting the nutrition needs of young infants. It offers health, physical, and psychological benefits to infants that influence health outcomes later in life. Breastfeeding must be part of a broader strategy to reduce existing health disparities.

Advocate for Policy Change

- Support legislation to eliminate barriers to breastfeeding. More than half of the states have enacted legislation to address breastfeeding in public, on the job, and on jury duty (82).
- Advocate for other policy changes affecting a woman's ability to continue breastfeeding, including longer family leave, facilities for child care and breastfeeding at the worksite or nearby in the community, paid lactation or milk expression breaks, flexible employment arrangements, breastfeeding support personnel/lactation consultation, and third-party reimbursement for lactation consultation and management services.
- Encourage school boards to review curriculum to ensure that breastfeeding is presented as the norm in texts, other resources, and classroom discussion at elementary and secondary schools. Dietetics professionals can volunteer to work with curriculum committees and science fair committees, and can guest lecture in classes such as social studies, life management, and science.
- Advocate for adequate facilities and breaks for mothers who are students and those who are teachers.

Conduct Empirical Research

- Take the initiative to conduct empirical research. Research is needed on topics such as cultural influences on infant feeding, social marketing of breastfeeding, effectiveness of breastfeeding promotion programs, cost-effectiveness, hospital/clinic use rates, eliminating barriers to extended breastfeeding, and nutri-

ent needs for women and children with special needs. Research should be theory-based and have policy implications. Larger-scale studies with better designs are needed.

- Develop and/or advocate for a consistent definition of breastfeeding in research studies to improve the understanding of the benefits of exclusive breastfeeding.
- Support a national policy to track breastfeeding trends using nonproprietary data. Policies are also needed to centralize national infant and child morbidity and mortality data.

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ADA position adopted by the House of Delegates on March 16, 1997, and reaffirmed on September 12, 1999, and June 6, 2003. The update will be in effect until December 31, 2008. The ADA authorizes republication of the position, in its entirety, provided full and proper credit is given. Requests to use portions of this position must be directed to ADA Headquarters at 1-800-877-1600, ext 4835, or ppapers@eatright.org. **Authors:** Delores C. S. James, PhD, RD (University of Florida, Gainesville, FL); Brenda Dobson, MS, RD (Iowa Department of Public Health, Des Moines, IA). **Reviewers:** Jessica Donze Black, MPH, RD (ADA, Washington, DC); Dietetic Technicians in Practice Dietetic Practice Group (Josie Klein, DTR, Mount Olivet Careview, Minneapolis, MN, and Connie Ulrich, DTR, Children's Mercy Hospital, Kansas City, MO); Deborah Krauter, RD (Massachusetts Department of Public Health, Boston, MA); Esther Myers, PhD, RD (ADA, Chicago, IL); Judith B. Roepke, PhD, RD (Ball State University, Muncie, IN); Jane V. White, PhD, RD, FADA (University of Tennessee-Knoxville, Knoxville). **APC Workgroup:** Ida Laquatra, PhD, RD (chair); Cynthia Taft Bayerl, MS, RD; Rachelle Lessen, MS, RD (content advisor).



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15 May 2007

To: Chairman Senator Carpenter
Committee on Public Health, Senior Issues, Long Term Care and Privacy
From: Ingrid Andersson, CNM, MSN, on behalf of the Wisconsin Chapter of the
American College of Nurse Midwives.

Senator Carpenter and Committee members, thank you for the opportunity to provide comments on Senate Bill 30. My name is Ingrid Andersson. I am licensed by the State of Wisconsin as a Registered Nurse and a Certified Nurse Midwife (CNM). I am here today on behalf of the Wisconsin Chapter of the American College of Nurse Midwives (ACNM) to testify in support of Senate Bill 30.

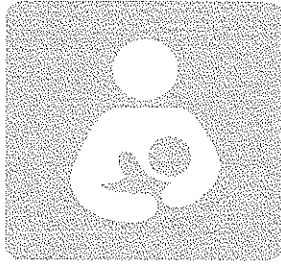
The American College of Nurse Midwives supports public policy that promotes the health of mothers and infants in Wisconsin. Nurse midwives often have clients who are committed to breastfeeding their babies. Yet despite their commitment to being the best mothers they can be and following all health and medical recommendations for nurturing healthy children, many of our clients tell us stories of feeling shamed, shunned and isolated when they breastfeed their babies in public places. New mothers have told me stories of being asked to feed their baby in utility closets, in unhygienic public restrooms, or behind curtains, and even to leave a store or restaurant.

My clients know that breastfeeding does not qualify as public indecency in Wisconsin. They know they have legal protection, but they do not always feel legally *empowered* to exercise their right. When you add workplace challenges and normal parenting challenges to the cultural challenges of public discrimination, you may have the explanation for the fact that Wisconsin rates for breastfeeding lag behind national averages. Of the 36 states that have laws specifically allowing women to breastfeed in any public or private location, two-thirds of them have breastfeeding rates better than Wisconsin. Four-out-of-five states that have achieved the Healthy People 2010 objectives for breastfeeding rates possess public protection laws.

SB 30 can legally empower mothers in Wisconsin to breastfeed their babies by helping remove cultural barriers to breastfeeding. We have a long way to go before we reach the United States Healthy People 2010 goals for breastfeeding initiation (75%), breastfeeding at 6 months (50%), and breastfeeding at one year (25%). Passage of SB 30 would send a powerful message to the citizens of Wisconsin that you, our state leaders, prioritize the health and wellbeing of mothers and children.

Sincerely,

Ingrid Andersson CNM, MSN
for ACNM-WI



Madison Breastfeeding Promotion Network

*Volunteers and Health professionals working to promote
and support breastfeeding in the Madison area.*

Throughout the State of Wisconsin, breastfeeding women are being harassed while making the very best nutritional choice for their children. Not only is this bill about a women's right to breastfeed in public, it is a bill about a baby's right to eat whenever and wherever he/she needs to. In 2005 the CDC recommended that legislation ensuring "the right to breastfeed" is an appropriate intervention to increase the public acceptance of breastfeeding. I applaud Sen. Risser & Rep. Wasserman for bringing such legislation forward in our state.

The Madison Breastfeeding Promotion Network is a coalition with over 50 members who are focused on supporting breastfeeding promotion. I am here today representing those members (which include physicians, nurses, IBCLC's, and community members) and I ask you to enthusiastically support SB 30. The majority of our members either currently or previously have worked directly with women and families who make the important and best nutritional choice to breastfeed. We have all heard stories of harassment of breastfeeding mothers in public, and we have heard what a barrier to continued breastfeeding this harassment has been. It is our belief that this bill will provide a legal basis to protect a woman's right to feed her baby wherever she has a right to be.

Additionally, the passage of this bill will support the strong and ongoing efforts of breastfeeding promotion by the Department of Health and Family Services, local public health agencies, clinics and hospitals across the state. Virtually every health organization educates pregnant families that nursing a child for the first year of life is the recommended feeding method. Passing this bill will provide the mothers, who we are encouraging to nurse for at least a year, with another system of support. When mothers are asked to leave a public place, they must be able to say, the law protects my right to nurse my baby here.

Moreover, by supporting breastfeeding mothers through the passage of SB 30, we as a state benefit. The environmental and economic benefits of breastfeeding are substantial.

- Breastfeeding is better for our environment because there is less trash and plastic waste compared to that produced by formula cans and bottle supplies.
- The State of Wisconsin could save money via a reduction in healthcare cost; because breastfed babies have fewer illnesses, fewer clinic visits, and fewer hospitalizations.
- A growing body of evidence suggests that breastfed infants receive protection against childhood obesity, which is important for our state because Wisconsin is ranked 26th in overweight and obesity prevalence among all states.

As you have heard, the benefits that are encompassed in breastfeeding include; health, psycho-social, societal, environmental and economic arenas. The State of Wisconsin should do everything possible to support a women's choice to breastfeed her child.

Information on the 1990 Census

What to Expect

The 1990 Census is the first time that the Census Bureau will be conducting a full count of the population in the United States. This is a major milestone in the history of the Census Bureau.

Throughout the history of the Census Bureau, there has been a constant effort to improve the quality of the data collected. This effort has been made through a variety of means, including the use of new technology, the development of new methods of data collection, and the implementation of new procedures for the processing and tabulation of the data. The 1990 Census is no exception. It is the first time that the Census Bureau will be using a new method of data collection, the use of a computerized system for the processing and tabulation of the data. This new method will allow the Census Bureau to collect and process the data more efficiently and accurately than ever before.

The 1990 Census is also the first time that the Census Bureau will be using a new method of data collection, the use of a computerized system for the processing and tabulation of the data. This new method will allow the Census Bureau to collect and process the data more efficiently and accurately than ever before. The 1990 Census is also the first time that the Census Bureau will be using a new method of data collection, the use of a computerized system for the processing and tabulation of the data. This new method will allow the Census Bureau to collect and process the data more efficiently and accurately than ever before.

Additional information on the 1990 Census is available on the Census Bureau's website. The website provides information on the 1990 Census, including the date of the census, the location of the census, and the methods of data collection. The website also provides information on the 1990 Census, including the date of the census, the location of the census, and the methods of data collection.

For more information on the 1990 Census, please contact the Census Bureau at 1-800-554-4800. The Census Bureau is committed to providing the best possible service to the public.

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DeLong, Russell

From: Oppelt, Judy L. [OppeltJL@co.outagamie.wi.us]
Sent: Monday, May 14, 2007 10:54 AM
To: Sen.Carpenter; Sen.Schultz; Sen.Coggs; Sen.Cowles; Sen.Kreitlow
Subject: Allow Mothers to Breastfeed in Public

Support our Breastfeeding Moms. Please vote for

Senate Bill 30

Relating to: permitting a mother to breast-feed in any public or private location where she is otherwise authorized to be.

Thank you for your support for babies and improving the Health Priorities of Wisconsin to help increase breastfeeding.

Judy L. Oppelt
Outagamie County WIC Program

05/15/2007

Breastfeeding stories in Wisconsin

These stories have been collected for educational purposes. The women have shared these stories in hopes that someday there will be a protected right to breastfeed and pump breastmilk for their babies.

JC Penney West, Madison, August 2006 – Alicia Butz

I was told by an employee that the bathrooms are a more appropriate place to breastfeed.

Dane County YMCA East, Madison, July 2006 – Jessica Grant

Last summer at the YMCA a friend and I were watching our older boys play at Jack Splash and were nursing our babies. A lifeguard came up to us and said, "It's OK to do that here, you just need to cover up." We were too surprised to say anything, so we tried to cover up as best we could. I went back later to talk with the Aquatic Director about their policy on breast feeding. We were basically told that their policy is what the lifeguard said. It's OK to nurse but you need to be "discreet" because the Y is a family place. It's terribly ironic that this business sees breastfeeding as not compatible with family activities when I was there with my family. It was a good thing that my child was done nursing, because she wouldn't have nursed in the heat while covered up.

Victoria's Secret, Burlington, June 22, 2006 – Rebecca Cook

I was shopping at a Victoria's Secret on June 22, 2006 with a friend, I couldn't find anything that I liked, and my friend was shopping around their fragrance section when my daughter got restless. There weren't any benches outside of the store, so I went to the back to find a dressing room (so I wouldn't have to go in search of a place to sit down.) I asked the attendant for one to nurse my baby and she said they were all full. There was enough room in the area where you wait for a dressing room that I just said I'd settle down on the floor and nurse her there, that I'm not shy. Another one of the women working there said, "No, you'll need to use the restroom," and proceeded to unlock the employee bathroom. I firmly said, "No! I don't eat in the restroom. She's not going to eat in the restroom!" At that moment, a woman came out of a dressing room, so I went into it. While I was in the dressing room, the employees were standing outside of my door talking about how they were in the middle of their biggest sale and needed to get people in and out of dressing rooms as quickly as possible (to each other, not to me.) Their talking was distracting my daughter, so we left.

I called the manager to complain that one of the employees asked me to go to the bathroom to nurse and she said, "Well, she was probably concerned that a patron would be offended at the sight of your breast." After that, I told the woman that their models and mannequins show more flesh than the average nursing mom, and that it's inappropriate to ask a nursing mother to use the restroom, and if a patron complains, they can politely tell them to look the other way. I then called the corporate customer service line, and the customer service rep said that they don't allow people to try on clothing in the middle of the sales floor, and that's why they wouldn't allow me to nurse on the sales floor.

After telling my story on mothering.com, another woman in Boston was harassed at a Victoria's Secret the very next day. We helped organize a modest nationwide nurse-in at Victoria's Secret and generate a bit of media attention about the problem.

Limited Too, Mayfair Mall, Milwaukee, April 2006 – Carrie Bondioli

My 11-year-old daughter received some clothing from her aunt that didn't fit. We decided to exchange them at the Limited Too store where the clothing was originally purchased. My daughter went into the dressing room, and as my sister-in-law and I sat on some nice oversized chairs nearby, my nursling decided it was time for lunch. No one seemed to notice. My older daughter came out and she and my sister-in-law went to the back of the store to deal with the exchanges while I finished up. Suddenly a store clerk in her early 20's approached and said, "Ma'am, could I ask you to nurse in a fitting room?"

I looked in the room which had a tiny three legged stool and decided "no" to the uncomfortable accommodations.

She then replied, "Well, this is a little girl's store and that is gross."

To this I responded, "What better way then, to show girls that 'breast is best' for their babies?"

The clerk attempted again, "But could you just go?"

After my nursling finished up about a minute later, we all left the store. What really hit me was that this store encourages girls to be sexy prematurely, when they are still too young to know what kind of messages they are sending. Breasts are already being portrayed as sexual objects, not means of nurturance. The act of nursing my daughter is more offensive to the general public than fastening messages on a young girl's butt to call attention to passersby, or selling thong-styled, lacy underwear for a 10-year-old. The fact that she used the word "gross" to describe an innate human behavior that has existed for women and babies since the beginning of time really says something about the current ideas and philosophies

of our society. I can think of all kinds of things that are "gross," like commercializing and marketing sex to preteens and detaching girls from the natural powers of their bodies.

UW Medical Foundation, Madison, March 31, 2006 – Fran Weintraub, MD, FAAP

I had computer training for 8 hours in a UW Medical foundation administration type of building. I asked the woman at the front desk where I could pump and she directed me to a shower stall within the bathroom. I told her it was not acceptable to pump in a restroom and made a tiny bit of fuss. Later she said they could find an empty conference room but by then I had called my husband to bring the baby for me to nurse.

WPS, Madison, January 2006 – Anonymous

I was told that I'm only allowed to use the unisex bathroom at work to pump. I think it's disgusting that I have to pump in there. There needs to be incentives for employers to set up something, anything, better than a bathroom for women to pump in.

St. Aloysius Church, Sauk City, Winter 2005 – Mary Fabian

We moved here from Minnesota in 2001. In the past 5 years, I have experienced more harassment for my breastfeeding in America's Dairyland than I ever did in The Land of 10,000 lakes! You'd think with all the dairy farmers, breastfeeding would be more accepted in this state. It's not! Our homeschooling group was attending a daily Mass, on a weekly basis (Thursday mornings) and several of the Moms in the group were breastfeeding children. The Pastor contacted me after Mass one day to tell me that he had received several complaints about the "breastfeeding during Mass" being very distracting and was it possible to feed our children before we came to Mass instead. I explained to him that there are LOTS of distractions during Mass that are far more irreverent (cell phones going off, immodest dress, etc.) Getting up to leave Mass to nurse our children and then coming back in would be more distracting than simply quietly nursing during the Mass itself. I also pointed out that The Blessed Virgin Mary nursed Jesus for at least 2 years! Nothing officially happened...except we all felt uncomfortable nursing our children from that point forward. This incident took place in the winter of 2005.

East Towne Mall, Madison, July 2005 – Karissa Andrews

When my baby was just 3 weeks old, I was harassed at the East Towne mall by an employee that told me to leave, cover up, and that she had alerted security. Two security officers circled around me, intimidating me until I finally decided to go nurse him in my hot van. It was a horrible experience no one should ever have to endure.

Neenah Public Pool, June 2005 -- Amy Weinsheim

When Lola was just 5 weeks old, I was at the Neenah Public Pool with my entire family. I was fully clothed (skirt & t-shirt...NOT in a bathing suit) sitting on a chaise lounge in a corner of the deck nursing my infant when a lifeguard approached and asked me to please "do that" someplace else because this is a family pool. She asked me 3 times and 3 times I told her very pleasantly that I would not leave as I was there with my family. The pool manager then came over (a large man, quite overweight). He repeatedly told me that this was a family pool and everyone could tell what I was doing and they wanted me to do it someplace else...why couldn't I go in the bathroom to "do that". He stood within a couple inches of me with his arms folded looking down and even with my husband there would not leave me alone. After several minutes of him staring at me I said I was not going to be bullied into leaving and he finally left. After I was done nursing, I asked him how to get a refund for my season pass as I could not believe the way I had been treated and he ran out of the office blocking the door and yelled at me. I made a formal complaint to the City and contacted La Leche League and the ACLU. Unfortunately, nobody was willing to do more than tell me that this happens a lot. The Park & Rec dept. Manager eventually contacted me via e-mail to say she was sorry I had been offended and that they would do some education with their staff. Thankfully, I was not a brand new mother and had the backbone to stand up to this. It was the very first time I had ever been approached while nursing one of my children and I still get upset when I think about it. Both of those staff people should have been reprimanded and, at the very least, I should have received a formal apology from both of them.

Manawa, 2005 – Chris Solheim

I had a negative NIP experience at my child's daycare center. I was told I could not nurse in my child's classroom and would have to go elsewhere. The staff break room. This is after I had nursed in my older son in his classroom for months when the center had another director. "People weren't comfortable." "Other children might see your breast." Any child that had been there for more than 18 months would have already seen me nurse my older son.

I'm getting all worked up again this again (this was over a year ago). To make a long story short a compromise was worked out although I did it only because I had no other childcare readily available and my older son was very happy there. I'm so glad that we are not there anymore.

UW Hospital, Madison, September 2004 – Anonymous

I was not allowed to pump at work. I only got a one hour break while at work for 9 hours. I needed to pump more than just once in order to supply my 3 month old baby with enough breastmilk while I was away from him. However, my supervisor would not allow me to split up my break time in order to pump more than once in order to keep up my supply of milk. I was only able to pump 2-4 oz/per time and my baby was taking 6-8 oz./day while I was away. This was terribly frustrating for me since I wanted to exclusively breastfeed my son.

Lakeside Nursing Home, Chippewa Falls, November 2004 – Christa Emberts

I was in Lakeside nursing home in Chippewa Falls, WI. My baby and I were nursing discreetly when the supervisor of that floor approached me and asked me not to nurse in any vicinity where food was. Although I quietly obliged, I assured her that Wisconsin law stated that where I was allowed to be, my baby was allowed to nurse (even though I'm not sure if that was true, I wanted her to know that she was in the wrong, but I complied anyway).

Dane County YMCA, 2004 – Lisa Yeager

I was kicked out of the YMCA pool for breastfeeding Nick about 2 years ago. I was told that I shouldn't expose myself in an area where young children were swimming. She said it would be more appropriate to do so in the change rooms and cover with a shawl. Then when I gave her some (polite) backchat ie: "this is ridiculous...", the manager on duty cornered me on the way out as well. She said there was to be no eating or drinking in the pool area and that included breastfeeding Nick!

Waukesha/Hartland County, Fall 2003 – Kristin Sanden

I volunteered to help reshelve books in my children's school library when my youngest was a few months old. I thought this would be a nice way to help out with my baby rocked to sleep in a sling while I reached up and down to put books away. Sometimes my baby did need to nurse and I either stopped to nurse her in a chair or continued to nurse her in the sling. It did work well and I enjoyed the quiet time as I worked in the library when there were no classes in there. Occasionally a student came in to return a book; otherwise the only other person there was the library assistant. After a few weeks, I got a call from the head librarian asking me not to nurse my baby in the library. She stated she was supportive of breastfeeding and nursed her own babies, but that it wasn't appropriate in the school when children were around. She said she was concerned that she was going to start getting a bunch of calls from concerned parents. She suggested I nurse in the bathroom if needed (aren't there children in there?) or leave the baby at home. I did attempt to discuss counter-arguments and admitted that I might not have been as discrete as I normally would be since the library was typically empty, but I eventually decided to stop volunteering as the damage was already done and it wasn't worth the fight. I was surprised at my reaction which was of a sense of shame and a feeling that I did something "naughty". I felt like a kid getting reprimanded by a teacher. I was upset that I had to choose between my baby's needs and my desire (and what I felt was my responsibility) to help in my children's school. It was even more surprising that nursing was considered "taboo" in a supposedly child-centered institution.

Princeton Club East, Madison, July 2003 – Alicia Butz

I was feeding my daughter when an employee came up to me to tell me that a member had complained and the Princeton Club would like me to leave. I said that I needed to feed my daughter. He then told me that breastfeeding was disgusting and should only be done in the bathrooms. I told him I was staying and that if he'd like to throw me out, I needed to see the manager. I was not thrown out, but had been reduced to tears. I later found out that this experience was not uncommon at the club.

YMCA, Oshkosh, Nov/Dec. 2002 – Maggie Payne

A teacher had breastfed her children in a sling for years while she taught her class. No one had ever commented that she knew of. She was relatively certain that most folks didn't even know she was breastfeeding. The YMCA acquired a new female director who happened upon her class one day. Upon seeing the baby in the sling and breastfeeding she suspended the teacher for inappropriate behavior in a classroom and made a blanket policy that children of an instructor could not be present during a class even if the child was participating in the class as a member. All instructors' children, no matter what age, must either be left at home or put in drop off care. This policy then was extended to include anyone breastfeeding in the YMCA. The new policy read that breastfeeding must be done in the facilities provided for such activities, i.e. the family changing room...back to feeding in the *bathroom*. This policy did not include bottlefed babies, just those that are breastfed.

American Family Insurance, Madison, November 2002 – Anonymous

The pump in the lactation room at work was broken and I wanted to have my partner bring my child into work to nurse. I was told that because there was a no visitors policy that my child could not briefly breastfeed to help keep up my supply. My son is 13 weeks old and I'm not allowed to breastfeed at work. I just didn't know what to do with this situation.



State of Wisconsin

Department of Health and Family Services

Jim Doyle, Governor

Kevin R. Hayden, Secretary

TO: Senate Committee on Public Health, Senior Issues, Long Term Care and Privacy
FROM: Kathryn Pederson, Breastfeeding Coordinator & Nutritionist, DHFS
RE: Senate Bill 30

“Nutrition is essential for growth and development, health, and well-being. Behaviors to promote health should start early in life with breastfeeding and continue through life with the development of healthful eating habits.” Healthy People 2010, National Health Plan

Thank you Senator Carpenter and committee members for the opportunity to testify on behalf of the Department of Health and Family Services in favor of Senate Bill 30.

DHFS is required by state statute (s.250.07) to develop a State Health Plan. The well being of mothers and children is an important health goal in the State Health Plan because it predicts the health of the next generation in Wisconsin. Breastfeeding is an important part of both the “Adequate and Appropriate Nutrition” and “Overweight, Obesity, and Lack of Physical Activity” health priorities of the State Health Plan, Healthiest Wisconsin 2010. Both the National and the State Health Plans state: “By 2010, 75% of mothers will breastfeed their babies in early postpartum period, 50% will be breastfeeding at 6 months, and 25% will be breastfeeding at one year.”

Breastfeeding data is available from two sources. The Pediatric Nutrition Surveillance System (PedNSS) represents the Wisconsin WIC population (a higher risk population) and the National Immunization Survey (which represents the population as a whole.) The 2005 PedNSS report indicates that 59.9% of infants were breastfed at birth and that 24.2% are breastfed at 6 months and 16.4% are breastfed at 12 months. (For the state population, these percentages are 69.5%, 37.1%, and 18.9% respectively – below the national average for all 3 indicators and well below the state and national health plan objectives.)

It is very well documented that breastfeeding has health benefits for both the mother and child. Research studies show that children who are not breastfed have higher rates of mortality, meningitis, some types of cancers, asthma and other respiratory illnesses, bacterial and viral infections, ear infections, allergies, and obesity. The American Academy of Pediatrics recommends that mothers breastfeed exclusively for six months but continue breastfeeding for at least the first year of a child’s life. Thus, breastfeeding is a national and state public health strategy for health promotion and disease prevention – it is not only a personal woman’s decision or a lifestyle choice.

Women know the benefits of breastfeeding. Research provided through a USDA contract with a national social marketing organization indicated that almost all women on the WIC Program are aware of breastfeeding benefits, but they want and need help in overcoming barriers. A major barrier for many women is feeling like they are committing a crime if they breastfeed their baby in public.

Senate Bill 30 deals with breastfeeding in a positive way and is a statement that Wisconsin recognizes and supports the importance of breastfeeding. This legislation will help to increase the incidence and duration of breastfeeding by helping change the social culture around it.

The responsibility for achieving the State Health Plan goal of promoting, supporting, and protecting breastfeeding rests not only on the Department of Health and Family Services, but with all public partners in Wisconsin. Currently, 38 states and Puerto Rico have laws on their books protecting the rights of women to breastfeed in public. All Wisconsin mothers should have the opportunity to breastfeed their infants, and all infants should have the opportunity to be breastfed.

Thank you again for the opportunity to testify in favor of Senate Bill 30.



United States Breastfeeding
COMMITTEE
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BREASTFEEDING IN THE UNITED STATES: A NATIONAL AGENDA



U.S. Department of Health & Human Services
HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau



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The Strategic Plan of the United States Breastfeeding Committee reflects a collective
statement and is not necessarily representative of its individual member organizations.

Prepared by the United States Breastfeeding Committee in cooperation with the National Alliance for Breastfeeding
Advocacy and with support from the Maternal and Child Health Bureau, Health Resources and Services Administration,
Department of Health and Human Services.



United States Breastfeeding
COMMITTEE

PROTECTING • PROMOTING • SUPPORTING



protecting | promoting | supporting

BREASTFEEDING IN THE UNITED STATES: A NATIONAL AGENDA



foreword



The United States Breastfeeding Committee composed of representatives from health professional associations and relevant government departments and non-governmental organizations developed the following *Strategic Plan*.

The Health Resources and Services Administration's Maternal and Child Health Bureau has a long history of protecting, promoting and supporting breastfeeding in the United States. A landmark activity was the Surgeon General's Workshop in 1984, which identified six major areas for the breastfeeding initiative:

- **Improve professional education in human lactation and breastfeeding;**
- **Develop public education and promotion efforts;**
- **Strengthen the support for breastfeeding in the health care system;**
- **Develop a broad range of support services in the community;**
- **Initiate a national breastfeeding promotion effort directed at working women; and**
- **Expand research on human lactation and data collection on breastfeeding.**

Over the years there have been numerous other significant events that have culminated with the establishment of the United States Breastfeeding Committee in 1998. This committee, composed of representatives from health professional associations and relevant government

departments and non-governmental organizations, developed the following *Strategic Plan*. Through this plan we will hopefully see the recommendations from the Surgeon General's Workshop on Breastfeeding and Human Lactation fully implemented.

The timing of this *Strategic Plan* is fortuitous as the Surgeon General has released the *HHS Blueprint for Action on Breastfeeding*. The Blueprint is a comprehensive framework for increasing breastfeeding and for promoting optimal breastfeeding practices. Linking the *Blueprint* with the *Strategic Plan* of the U.S. Breastfeeding Committee provides a synergistic approach that will benefit America's mothers and children.

We thank our partners, especially those at the Centers for Disease Control and Prevention's Maternal and Child Nutrition Branch, who have supported us in this momentous effort, and we look forward to our continued collaboration as we work together to implement this *Strategic Plan for Protecting, Promoting, and Supporting Breastfeeding in the United States*.

Peter C. Van Dyck, M.D., M.P.H.
Associate Administrator for Maternal and Child Health

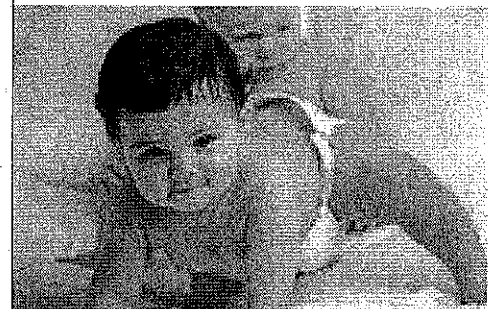
introduction

Starting in 1995, a small group of breastfeeding advocates met to discuss the need for coordination of breastfeeding activities in the U.S.

The development of the Strategic Plan, *Protecting, Promoting and Supporting Breastfeeding in the United States*, was one of four objectives developed by the National Breastfeeding Leadership Roundtable, the organizational precursor to the United States Breastfeeding Committee. Starting in 1995, a small group of breastfeeding advocates met to discuss the need for coordination of breastfeeding activities in the U.S. After conducting an intensive needs assessment, the National Alliance for Breastfeeding Advocacy (NABA) was formed to address needs not being met by organizations, government agencies or individuals. NABA convened the first National Breastfeeding Leadership Roundtable (NBLR) in January 1996 to determine if another organization was needed to move breastfeeding forward in this country. Working on the international model, the formation of this committee, if successful, would satisfy one of the four operational targets set forth by the 1990 Innocenti Declaration. This was to establish a multi-sectoral national breastfeeding committee composed of representatives from relevant government departments, non-governmental organizations, and health professional associations in every country.

It was agreed at that meeting of nineteen breastfeeding leaders to do four things. First, to support ongoing breastfeeding projects in the U.S. Second, to develop a strategic plan for breastfeeding in the U.S. Third, to formalize NBLR into the U.S. Breastfeeding Committee (USBC). And finally, to establish the organization of the USBC and its leadership, the NBLR continued to meet twice a year and in January 1998 voted to declare itself, with the encouragement of Assistant Surgeon General Dr. Audrey Nora, the United States Breastfeeding Committee.

The USBC is a collaborative partnership of organizations. The mission of the committee is to protect, promote and support breastfeeding in the U.S. The USBC exists to assure the rightful place of breastfeeding in society. To these ends, the USBC, supported by the Maternal and Child Health Bureau, developed this *Strategic Plan* for breastfeeding in the United States.



The formation of the USBC is among the most salient and distinguishing features of the progress that has occurred in the breastfeeding community since 1984.

Breastfeeding in the United States: Strategic Plan

Since the Surgeon General's Workshop in 1984, much has happened to advance the protection, promotion and support of breastfeeding for U.S. families. These efforts include the American Academy of Pediatrics 1997 policy statement, *Breastfeeding and the Use of Human Milk*, the introduction of the Maloney Bill in 1998, the Maternal and Child Health State Performance Measures, the 1998 National Breastfeeding Policy Conference and, facilitated by the National Alliance for Breastfeeding Advocacy, the establishment of the United States Breastfeeding Committee (USBC).

The policy recommendations from the National Breastfeeding Policy Conference, held in Washington, D.C. in November of 1998, provided a framework for setting a national policy agenda to protect, promote and support breastfeeding well into the 21st century. The mandate from this conference transferred the policy agenda to the USBC. The Federal Government, through the Health Resources and Services Administration's Maternal and Child Health Bureau, asked the committee to provide a strategic plan to implement this policy agenda.

The formation of the USBC is among the most salient and distinguishing features of the progress that has occurred in the breastfeeding community since 1984. It satisfies one of the four operational targets set forth by the 1990 Innocenti Declaration which was to establish a multi-sectoral national breastfeeding committee composed of representatives from relevant government departments, non-governmental organizations, and health professional associations.

The health of our Nation is one of our most important resources. Breastfeeding, a relatively basic, simple, and cost-effective measure, can have a significant impact on establishing the foundation for a lifetime of optimal health and can result in reduced health care spending. In recognition of this, the USBC has developed this strategic plan for breastfeeding in the United States.

**To improve the Nation's health by
working collaboratively to protect,
promote, and support breastfeeding.**

mission

vision

**In order to achieve optimal health,
enhance child development, promote
knowledgeable and effective parent-
ing, support women in breastfeeding,
and make optimal use of resources,
we envision breastfeeding as the
norm for infant and child feeding
throughout the U.S.**



goals | objectives

Accomplishing our mission requires setting forth concrete and challenging goals. These revolve around improvement in breastfeeding initiation and duration, reduction and removal of barriers to breastfeeding, equitable access to lactation care and services, and portrayal and acceptance of breastfeeding as the cultural norm for infant and child feeding. The overarching breastfeeding goal of Healthy People 2010 is a 75 percent initiation rate, a 50 percent continuation rate to 6 months, and a 25 percent rate at 1 year. To that end, we recommend the following:

I GOAL I

ASSURE ACCESS TO COMPREHENSIVE, CURRENT, AND CULTURALLY APPROPRIATE LACTATION CARE AND SERVICES FOR ALL WOMEN, CHILDREN AND FAMILIES.

GOAL STATEMENT:

All U.S. mothers should have the opportunity to breastfeed their infants and all infants should have the opportunity to be breastfed. By ensuring access to comprehensive, interdisciplinary, culturally appropriate lactation and breastfeeding care and services from pre-conception through weaning, all women will be empowered to breastfeed their infants exclusively for about 6 months and continue through the first year of life and beyond while introducing appropriate weaning foods.

OBJECTIVE A: Identify and disseminate evidence-based best practices and policies throughout the health care system.

STRATEGY 1: Develop a single overall national breastfeeding policy statement grounded on a foundation of evidence-based practice. The statement will be culturally appropriate, aim to eliminate disparities in care, and include all babies whether full term or preterm, healthy or sick.

ACTIVITIES:

- a) Fund and convene a national breastfeeding subcommittee to draft an evidence-based U.S. breastfeeding policy statement that will be submitted to member organizations for universal adoption.
- b) Encourage institutions including third party payers, hospitals, health care agencies, health professional organizations and others to adopt these policies.
- c) Encourage health professional associations, institutions, organizations and agencies to develop and implement practice guidelines congruent with the U.S. breastfeeding policy statement.
- d) Disseminate the policy statement to the general public and governmental agencies through governmental and non-governmental channels using the media, Internet sites, newsletters, bulletins, electronic mailing lists, meetings, and conferences.

STRATEGY 2: Ensure that every facility providing maternity services will offer effective, evidence-based breastfeeding care.

ACTIVITIES:

- a) Encourage the USBC member organizations to promote best hospital practices to their members such as those identified in the WHO/UNICEF Baby-Friendly Hospital Initiative.
- b) Encourage the U.S. Department of Health and Human Services [DHHS] to issue a statement urging all maternity care facilities to provide effective, evidence based breastfeeding practices such as those identified in the WHO/UNICEF Baby-Friendly Hospital Initiative.
- c) Encourage the utilization of measurable breastfeeding outcomes for facilities providing maternity services and encourage health care accrediting agencies to include these outcomes in their evaluation.
- d) Inform hospital administrators, members of Congress, health management companies and third party payers about the best maternity practices such as those identified in the Baby-Friendly Hospital Initiative.

OBJECTIVE B: Educate all health care providers and payers regarding appropriate breastfeeding and lactation support.

STRATEGY 1: Establish minimum competency-based standards of breastfeeding knowledge and skills for all maternal-child health care providers.

ACTIVITIES:

- a) Urge organizations responsible for accreditation of health professional education programs to require the use of relevant competency-based curricula on breastfeeding and lactation management.
- b) Ensure the development and dissemination of competencies and competency-based lactation management curricula for use in the training and education of health professionals.
- c) Urge private, state and national licensure and certification agencies to include questions regarding breastfeeding protection, promotion and support on their examinations.

STRATEGY 2: Encourage health care plans and other provider organizations to educate their providers, administrators, managers, and consumers about the importance of breastfeeding as part of an overall preventive health strategy.

ACTIVITIES:

- a) Support the expansion of continuing education (e.g., CME, CEU and CERP) and staff development programs pertaining to breastfeeding issues.
- b) Foster the integration of breastfeeding education and services into conferences, meetings, and written literature that are accessed by top levels of management companies and hospital administrators.

OBJECTIVE C: Ensure that all women have access to appropriate breastfeeding support within the family and/or community.

STRATEGY 1: Comprehensive and seamless lactation support programs will be encouraged between hospitals and communities.

ACTIVITIES:

- a) Ensure that all women have access to skilled lactation care.
- b) Facilitate the formation of mother-to-mother support groups and breastfeeding peer-counselor programs to help eliminate disparities in breastfeeding initiation and duration.
- c) Ensure that all women have access to referral services, "hot lines" and "warm lines" as needed.
- d) Develop and disseminate a valid and reliable community assessment tool that identifies referral services.

STRATEGY 2: Encourage third party health care payers to adequately reimburse for lactation and breastfeeding services and medically advised equipment.

ACTIVITIES:

- a) Create a task force to study the health care spending costs, employer costs, and family costs of breastfeeding and not breastfeeding.
- b) Encourage federally funded programs and all other third party payers to pay for breastfeeding equipment when medically advised.

OBJECTIVE D: Ensure the routine collection and coordination of breastfeeding data by federal, state, and local government and other organizations and foster additional research on breastfeeding.

STRATEGY 1: Collect timely breastfeeding initiation and duration data through existing and new channels.

ACTIVITIES:

- a) Encourage the federal government to explore and implement the collection of ongoing statistics of breastfeeding initiation, continuation, and exclusivity through survey, surveillance systems and program statistics.
- b) Encourage federal funding for breastfeeding surveillance at both Federal and State levels.
- c) Encourage all states to participate in breastfeeding data collection.
- d) Encourage development of incentives for participation in data collection.
- e) Propose and promulgate breastfeeding data elements for Health plan Employer Data Information Systems (HEDIS) and Consumer Assessment of Health Plans (CAHPS) including measurement for special and high-risk populations such as preterm infants.

STRATEGY 2: Encourage funding for clinical, epidemiological, programmatic, and other research on breastfeeding and human lactation.

ACTIVITIES:

- a) Contact governmental and private funding agencies, and encourage funding of breastfeeding research.
- b) Encourage the inclusion of evidence-based breastfeeding practices into databases such as the Cochrane database.
- c) Encourage the expansion of breastfeeding research to encompass issues such as program effectiveness, cost/benefit analysis, and emerging medical concerns.
- d) Convene a technical meeting on the cost-benefit of breastfeeding and the cost of artificial feeding.

All U.S. mothers should

have the opportunity to

breastfeed



their infants

and all infants should have

the opportunity to be breastfed.

GOAL II

ENSURE THAT BREASTFEEDING IS RECOGNIZED AS THE NORMAL AND PREFERRED METHOD OF FEEDING INFANTS AND YOUNG CHILDREN.

GOAL STATEMENT:

Breastfeeding should become the normative method of infant and young child feeding and should be woven into the foundation of society and family life.

OBJECTIVE A: Develop a positive and desirable image of breastfeeding for the American public.

STRATEGY 1: Develop and implement a national comprehensive and coordinated marketing program which portrays breastfeeding as normal, desirable and achievable.

ACTIVITIES:

- a) Conduct breastfeeding marketing research that is independent of formula company marketing research to provide data for a national breastfeeding campaign.
- b) Secure adequate funding for a national breastfeeding promotion campaign.
- c) Enlist the support of the National Ad Council or similar organizations to design a national campaign that creates positive breastfeeding images and eliminates the bottle as a symbol of infancy.
- d) Target specific populations for marketing, including but not limited to health care providers, hospitals, third party payers, business leaders, government, labor and education agencies, private sector labor organizations, women's groups, social welfare organizations, religious groups, judicial systems, and consumer groups.
- e) Develop white papers on selected breastfeeding topics for routine distribution to members of Congress and policy makers.
- f) Expand the Breastfeeding Media Watch to encompass all States and territories, and catalog acceptable and unacceptable breastfeeding images that appear in all forms of the media. Respond to both positive and negative publicity with issue letters and white papers.
- g) Provide the Federal Trade Commission and the Federal Communications Commission with guidelines and recommendations for acceptable advertising.
- h) Encourage publication of articles in advertising and trade journals that suggest ways to portray breastfeeding in a positive light and ways to eliminate bottles as the representative symbol of infancy.
- i) Establish a unified project to promote and recognize businesses supportive of breastfeeding mothers and families.
- j) Designate a Presidential (or Surgeon General's) Award program for a variety of breastfeeding support programs.
- k) Expand and financially support a rapid response system for both public relations and damage control.
- l) Establish and fund a national breastfeeding web site of the USBC with frequent updating for the media to access for correct breastfeeding information and hyperlinks to all member organizations.

- m) Establish a speakers bureau of breastfeeding experts and market this bureau to appropriate audiences.

STRATEGY 2: Develop and implement an educational curriculum relating to breastfeeding as the normal and preferred method of feeding infants and young children that is age appropriate for pre-Kindergarten through grade 12.

ACTIVITIES:

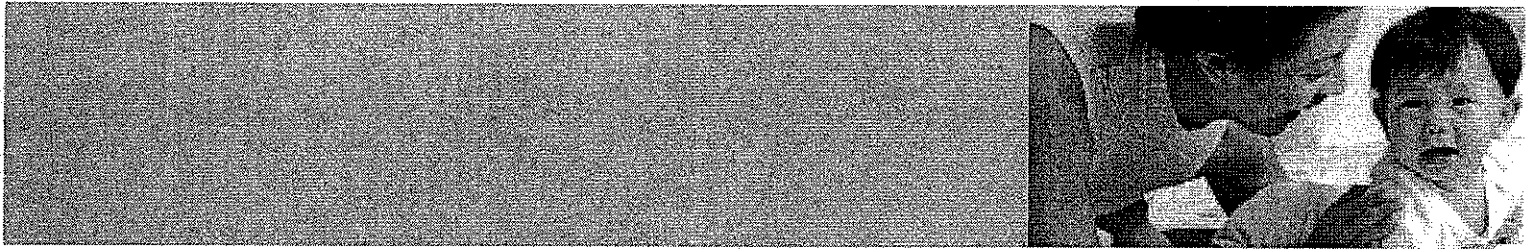
- a) Collect and review samples of existing curricula from around the country for different age groups.
- b) Develop a national curriculum in consultation with the U.S. Department of Education and educational experts.
- c) Disseminate the curriculum to all State and territorial departments of education, national teachers' groups, parent-teacher associations, and media services involved with children's education.
- d) Develop and implement a training program that will facilitate the use of the curriculum.

OBJECTIVE B: Reduce the barriers to breastfeeding posed by the marketing of breastmilk substitutes.

STRATEGY 1: Encourage the implementation of the International Code of Marketing of Breastmilk Substitutes.

ACTIVITIES:

- a) Form a multidisciplinary task force to explore the implementation of the International Code of Marketing of Breastmilk Substitutes (The Code) and all relevant WHO and UNICEF resolutions. Include marketing experts, lobbying experts, attorneys, and congressional staff on this task force.
- b) Gather systematic data on the state of The Code in the U.S. and publish and disseminate a report.
- c) Target education related to The Code (including the report mentioned above) to professional organizations, legislators, non-governmental organizations, the general public, the business community, hospitals, attorneys, and national women's organizations.
- d) Adapt the International Code language and documentation to fit the U.S. legal system.
- e) Create a panel to monitor and enforce The Code within the U.S.



GOAL III

ENSURE THAT ALL FEDERAL, STATE, AND LOCAL LAWS RELATING TO CHILD WELFARE AND FAMILY LAW RECOGNIZE AND SUPPORT THE IMPORTANCE AND PRACTICE OF BREASTFEEDING.

GOAL STATEMENT:

Lawmakers and policymakers will recognize breastfeeding as vital to the health, social and economic well-being of women, children, and families.

OBJECTIVE A: Ensure that all lawmakers and government officials at Federal, State, and local levels are aware of the importance of protecting, promoting, and supporting breastfeeding.

STRATEGY 1: Inform lawmakers and governmental officials to consider breastfeeding when addressing any policy or practice that has an impact on women or children.

ACTIVITIES:

- a) Identify breastfeeding issues that require action by lawmakers.
- b) Identify and train breastfeeding advocates to inform lawmakers.
- c) Develop legislative fact sheets for government and non-government agencies, especially those involved with underserved and special populations.
- d) Establish a database of legislation, policies, regulations, and legal precedents with implications for breastfeeding.
- e) Establish liaisons with the American Bar Association and other legal organizations and law schools to educate and work with attorneys and judges in supporting breastfeeding.

IV

GOAL IV

INCREASE PROTECTION, PROMOTION AND SUPPORT FOR BREASTFEEDING MOTHERS IN THE WORK FORCE.

GOAL STATEMENT:

Every woman, regardless of her employment status, will have the opportunity to breastfeed and/or provide breast milk to her child. Breastfeeding will be protected, promoted, and supported in the workplace through political, sociocultural, economic, and legal means in a way that protects family health and economic viability.

OBJECTIVE A: The rights of women in the workplace will be recognized in public and private sectors.

STRATEGY 1: Raise awareness in both the public and private sectors about the need to establish the rights of breastfeeding women in the workplace.

ACTIVITIES:

- a) Create and disseminate an overview of labor laws, regulations, gender equity issues, policies, agency declarations, or statements (e.g., Occupational Safety and Health Administration) where breastfeeding should be addressed.
- b) Educate the public about the legal rights of breastfeeding mothers, whether in the formal or informal workplace, paid or unpaid, through print, radio, and televised and electronic media in broad circulation.

OBJECTIVE B: Ensure that all mothers are able to seamlessly integrate breastfeeding and employment.

STRATEGY 1: Codify policy, legislation, and regulations that will enable parents to have flexibility in adapting their work schedules and employment arrangements for at least one year after birth to facilitate breastfeeding and/or the provision of breastmilk to their child.

ACTIVITIES:

- a) Convene a Technical Advisory Group to explore paid maternity leave, implementation of the recommendations of the International Labor Organization (ILO) conventions, the Family Medical Leave Act, and other pertinent legislation regarding employment.
- b) Develop and maintain relationships with key legislators in order to provide information that will enable them to initiate and support legislation related to breastfeeding and the workplace.
- c) Devise and disseminate education and outreach activities individualized for business and labor groups.

- d) Introduce into the employment arena existing recommendations including proceedings from ILO Conventions of 1919 and 1952, the Surgeon General's Workshop, the Quezon City Declaration, Healthy People 2010, Call to Action-Maternal and Child Health Inter-Organizational Nutrition Group (MCHING), Beijing Platform for Action, the Innocenti Declaration, and the National Breastfeeding Policy Meeting.
- e) Ensure representation for breastfeeding at conferences related to women in the workplace such as AFL-CIO Working Woman 2000.
- f) Ensure representation at policy development meetings related to women in the workplace.
- g) Incorporate breastfeeding into the Civil Rights Act, Pregnancy Discrimination Act, and other Federal regulations and legislation where appropriate.
- h) Incorporate breastfeeding into State-based legal protections for working women.

STRATEGY 2: Increase the number of work site environments that are modified or adapted to be supportive of breastfeeding employees.

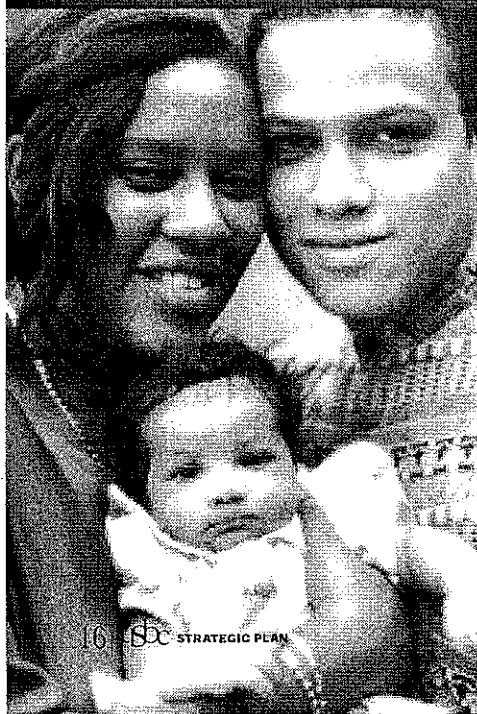
ACTIVITIES:

- a) Encourage employers through education and outreach to offer a variety of flexible work programs such as earned time, part-time, job sharing, graduated return to work, flex time, compressed work week, telecommuting, and onsite childcare.
- b) Identify and showcase demonstration projects, successful models, or better practices for breastfeeding in the workplace.
- c) Conduct research at local, state, or national levels to determine the needs of all mothers returning to work.
- d) Encourage employers to conduct needs assessments of their breastfeeding employees or employees of reproductive age, and develop programs supportive of the breastfeeding mother.
- e) Create innovative situational models for different types of work settings relative to time, space, and the breastfeeding needs of the work force.
- f) Educate the workforce on the economic costs of artificial feeding in the working community according to work site needs.

The United States Breastfeeding Committee, Inc. is comprised of Governmental, Educational and Not-For-Profit organizations that share the common mission of protecting promoting and supporting breastfeeding in the United States.

member organizations

Academy of Breastfeeding Medicine
Academy for Educational Development
American Academy of Pediatrics
American College of Nurse Midwives
American College of Obstetricians and Gynecologists
American College of Osteopathic Pediatricians
American College of Preventive Medicine
American Public Health Association
Association of State and Territorial Public Health Nutrition Directors
Association of Women's Health, Obstetrics and Neonatal Nurses
Baby-Friendly USA
Best Start Social Marketing
Centers for Disease Control/Maternal and Child Nutrition Branch
Center on Budget and Policy Priorities
Coalition for Improving Maternity Services
Department of Health and Human Services/Food and Drug Administration
Department of Health and Human Services/Health Resources Services Administration/Maternal and Child Health Bureau
Healthy Children 2000
Human Milk Banking Association of North America
International Board of Lactation Consultant Examiners
International Lactation Consultant Association
Keck School of Medicine, University of Southern California
La Leche League International
Lamaze International
Morgan State University
National Alliance for Breastfeeding Advocacy
NABA
Research, Education and Legal
National Association of Pediatric Nurse Associates and Practitioners
National Association of WIC Directors
National Commission on Donor Milk Banking
National Healthy Mothers, Healthy Babies Coalition
Office on Women's Health, Department of Health and Human Services
United States Department of Agriculture/Food and Nutrition Services/WIC
University of California Los Angeles School of Public Health
University of Rochester, School of Medicine and Dentistry
Wellstart International
Women's International Public Health Network



GOAL I

Assure access to comprehensive, current, and culturally appropriate lactation care and services for all women, children and families.

GOAL II

Ensure that breastfeeding is recognized as the normal and preferred method of feeding infants and young children.

GOAL III

Ensure that all Federal, State, and local laws relating to child welfare and family law recognize and support the importance and practice of breastfeeding.

GOAL IV

Increase protection, promotion and support for breastfeeding mothers in the work force.



United States Breastfeeding
COMMITTEE
PROTECTING • PROMOTING • SUPPORTING



U.S. Department of Health & Human Services

Health Resources and Services Administration
Maternal and Child Health Bureau

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